



ADMINISTRATIVE RULES OF MONTANA



37.40.330 SEPARATELY BILLABLE ITEMS

- (1) In addition to the amount payable under the provisions of ARM 37.40.307(1) or (4) , the department will reimburse nursing facilities located in the state of Montana for the following separately billable items. Refer to the department's nursing facility fee schedule for specific codes and refer to healthcare common procedure coding system (HCPCS) coding manuals for complete descriptions of codes:
 - (a) ostomy surgical tray;
 - (b) ostomy face plate;
 - (c) ostomy skin barriers;
 - (d) ostomy filter;
 - (e) ostomy bags (pouches) ;
 - (f) ostomy belt;
 - (g) adhesive;
 - (h) adhesive remover;
 - (i) ostomy irrigation set and supplies;
 - (j) ostomy lubricant;
 - (k) ostomy rings;
 - (l) ostomy irrigation supply, cone/catheter, including brush;
 - (m) catheter care kit;
 - (n) urine test or reagent strips or tablets;
 - (o) blood tubing, arterial or venous;
 - (p) blood glucose test strips for dialysis;
 - (q) blood glucose test or reagent strips for home blood glucose monitor;
 - (r) implantable access catheter (venous, arterial, epidural, subarachnoid, peritoneal, etc.) external access;
 - (s) gastrostomy/jejunostomy tube, any material, any type;
 - (t) oropharyngeal suction catheter;

- (u) implanted pleural catheter;
- (v) external urethral clamp or compression device;
- (w) urinary catheters;
- (x) urinary insertion trays (sets) ;
- (y) urinary collection bags;
- (z) tracheostomy care kit for established tracheostomy;
- (aa) tracheostomy, inner cannula (replacement only) ;
- (bb) oxygen contents, portable, liquid;
- (cc) oxygen contents, portable, gas;
- (dd) oxygen contents, stationary, liquid;
- (ee) oxygen contents, stationary, gas;
- (ff) cannula, nasal;
- (gg) oxygen tubing;
- (hh) regulator;
- (ii) mouth piece;
- (jj) stand/rack;
- (kk) face tent;
- (ll) humidifier;
- (mm) breathing circuits;
- (nn) respiratory suction pump, home model, portable, or stationary;
- (oo) nebulizer, with compressor;
- (pp) feeding syringe;
- (qq) nasal interface (mask or cannula type) used with positive airway device;
- (rr) stomach tube - levine type;
- (ss) nasogastric tubing (with or without stylet) ;
- (tt) nutrition administration kits;
- (uu) feeding supply kits;
- (vv) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for residents who, because of chronic illness or trauma, cannot be sustained through oral feeding. Payment for these solutions will be allowed only where the department determines they are medically necessary and appropriate, and authorizes payment before the items are provided to the resident;

- (ww) routine nursing supplies used in extraordinary amounts and prior authorized by the department;
- (xx) oxygen concentrators and portable oxygen units (cart, E tank and regulators), if prior authorized by the department.
 - (i) The department will prior authorize oxygen concentrators and portable oxygen units (cart, E tank and regulators) only if:
 - (A) The provider submits to the department documentation of the cost and useful life of the concentrator or portable oxygen unit, and a copy of the purchase invoice.
 - (B) The provider maintains a certificate of medical necessity indicating the PO2 level or oxygen saturation level. This certificate of medical necessity must meet or exceed Medicare criteria and must be signed and dated by the patient's physician. If this certificate is not available on request of the department or during audit, the department may collect the corresponding payment from the provider as an overpayment in accordance with ARM 37.40.347.
 - (ii) The provider must attach to its billing claim a copy of the prior authorization form.
 - (iii) The department's maximum monthly payment rate for oxygen concentrators and portable oxygen units (cart, E tank and regulators) will be the invoice cost of the unit divided by its estimated useful life as determined by the department. The provider is responsible for maintenance costs and operation of the equipment and will not be reimbursed for such costs by the department. Such costs are considered to be covered by the provider's per diem rate.
- (2) The department may, in its discretion, pay as a separately billable item, a per diem nursing services increment for services provided to a ventilator dependent resident, trach dependent resident, behavior related needs resident, wound care resident, bariatric care resident, and residents with traumatic brain injury (TBI) diagnoses if the department determines that extraordinary staffing by the facility is medically necessary based upon the resident's needs.
 - (a) Payment of a per diem nursing services increment under (2) for services provided to a ventilator dependent resident shall be available only if, prior to the provision of services, the increment has been authorized in writing by the department's senior and long term care division. Approvals will be effective for one month intervals and reapproval must be obtained monthly.
 - (b) The department may require the provider to submit any appropriate medical and other documentation to support a request for authorization of the increment. Each calendar month, the provider must submit to the department, together with reporting forms and according to instructions supplied by the department, time records of nursing services provided to the resident during a period of five consecutive days. The submitted time records must identify the amount of time care is provided by each type of nursing staff, i.e., licensed and nonlicensed.
 - (c) The increment amount shall be determined by the department as follows. The department shall subtract the facility's current average Medicaid case mix index (CMI) used for rate setting determined in accordance with ARM 37.40.320 from the CMI computed for the ventilator dependent resident, determined based upon the current minimum data set (MDS)

information for the resident in order to determine the difference in case mix for this resident from the average case mix for all Medicaid residents in the facility. The increment shall be determined by the department by multiplying the provider's direct resident care component by the ratio of the resident's CMI to the facility's average Medicaid CMI to compute the adjusted rate for the resident. The department will determine the increment for each resident monthly after review of case mix information and five consecutive day nursing time documentation review.

- (3) The department will reimburse for all Montana Medicaid covered services delivered via telemedicine/telehealth originating site fees as long as such services are medically necessary and clinically appropriate for delivery via telemedicine/telehealth, comply with the guidelines set forth in the applicable Montana Medicaid provider manual, and are not a service specifically required to be face-to-face.
- (4) The department will reimburse for separately billable items at direct cost, with no indirect charges or mark-up added. For purposes of combined facilities providing these items through the hospital portion of the facility, direct cost will mean invoice price to the hospital with no indirect cost added.
 - (a) If the items listed in (1)(a) through (1)(ax) are also covered by the Medicare program and provided to a Medicaid recipient who is also a Medicare recipient, reimbursement will be limited to the lower of the Medicare prevailing charge or the amount allowed under (3). Such items may not be billed to the Medicaid program for days of service for which Medicare Part A coverage is in effect.
 - (b) The department will reimburse for separately billable items only for a particular resident, where such items are medically necessary for the resident and have been prescribed by a physician.
- (5) Physical, occupational, and speech therapies which are not nursing facility services may be billed separately by the licensed therapist providing the service, subject to department rules applicable to physical therapy, occupational therapy, and speech therapy services.
 - (a) Maintenance therapy and rehabilitation services within the definition of nursing facility services in ARM 37.40.302 are reimbursed under the per diem rate and may not be billed separately by either the therapist or the provider.
 - (b) If the therapist is employed by or under contract with the provider, the provider must bill for services which are not nursing facility services under a separate therapy provider number.
- (6) Durable medical equipment and medical supplies which are not nursing facility services and which are intended to treat a unique condition of the recipient which cannot be met by routine nursing care, may be billed separately by the medical supplier in accordance with department rules applicable to such services.
- (7) All prescribed medication may be billed separately by the pharmacy providing the medication, subject to department rules applicable to outpatient drugs. The nursing facility will bill Medicare directly for reimbursement of Medicare Part B covered drugs and vaccines and their administration when they are provided to an eligible Medicare Part B recipient. Medicaid reimbursement is not available for Medicare Part B covered drugs and vaccines and related administration costs for residents that are eligible for Medicare Part B.

- (8) Nonemergency routine transportation for activities other than those described in ARM 37.40.302(11), may be billed separately in accordance with department rules applicable to such services. Emergency transportation may be billed separately by an ambulance service in accordance with department rules applicable to such services.
- (9) The provider of any other medical services or supplies, which are not nursing facility services, provided to a nursing facility resident may be billed by the provider of such services or supplies to the extent allowed under and subject to the provisions of applicable department rules.
- (10) The provisions of (3) through (7) apply to all nursing facilities, including intermediate care facilities for individuals with intellectual disabilities, whether or not located in the state of Montana.
- (11) Providers may contract with any qualified person or agency, including home health agencies, to provide nursing facility services. However, except as specifically allowed in these rules, the department will not reimburse the provider for such contracted services in addition to the amounts payable under ARM 37.40.307.

Authorizing statute(s): 53-2-201, 53-6-113, MCA

Implementing statute(s): 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

History: NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2003 MAR p. 1294, Eff. 7/1/03; AMD, 2004 MAR p. 1479, Eff. 7/2/04; AMD, 2005 MAR p. 1046, Eff. 7/1/05; AMD, 2007 MAR p. 1100, Eff. 8/10/07; AMD, 2011 MAR p. 1375, Eff. 7/29/11; AMD, 2016 MAR p. 1071, Eff. 7/1/16; AMD, 2020 MAR p. 1330, Eff. 7/25/20.